Victims Compensation Quarterly

Dedicated to Providing Compassionate Services to our Constituents

NEW DIRECTOR WILL LEAD VICTIMS PROGRAM INTO NEW MILLENNIUM

On January 1, **Kelly Brodie** began her appointment as the Board of Control's new Executive Director.

Prior to this appointment, Ms. Brodie was the Compensation Director of the Crime Victim Assistance Program within the Iowa Department of Justice. She is currently serving her second term as the president of the National Association of Crime Victim Compensation Boards, and was formerly Iowa's VOCA assistance administrator.

One of her first goals is to simplify and revise the VOCP application.

Other goals include:

- Installing a new and improved data base for the VOCP;
- Scanning of all file documents to eliminate paper files;
- Conducting on-going client surveys to assess customer satisfaction;

Kelly Brodie
Executive Director

- Revising and personalizing written communications to victims/claimants.

Her plans for outreach include establishing focus groups throughout the state and meeting with constituents to determine how to inform as many victims as possible about the compensation and assistance available to them.

Ms. Brodie plans to increase distribution of the new VOCP applications by making them available in places such as law enforcement agencies, hospitals and social service agencies.

In 1989, when the Iowa Attorney General's Office first began administering the Iowa Program, she worked for 18 months as a claims investigator. She has served as the Iowa Program's Director for the past nine years.

During her tenure as Director, the Iowa Program received national recognition for its success in delivering quality and timely services to crime victims. Under her direction, the Program developed and implemented an automated system for claims processing, increased applications by 702%, and reduced the average claims processing time from twenty-

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NEW AND EXPANDED TRAINING CURRICULUM

Consistent with the Board's goal to provide an environment that supports continuous learning, the VOCP recently developed a new and extended training curriculum for VOCP claims verification.

Claims verification training has been revised from one three week session to two two-week sessions, for a total of four weeks. During the first two weeks, the training focuses exclusively on claim eligibility. During this time, trainees work with actual VOCP claims and utilize various reference materials and other resources to resolve issues that may affect eligibility, such as involvement or participation in the crime.

During the second two weeks, trainees learn to process payments for various types of losses, such as medical, income/support, or funeral/burial expenses. This new "hands-on" approach allows trainees to practice and review skills that are essential to job performance. Trainers are available to work with each trainee to provide feedback and assistance. The training includes a thorough overview of the Board's Goals and Objectives, and the statutes that govern the VOCP.

The new curriculum also includes "role-playing" activities. This provides trainees the opportunity to practice human relations and communications skills that are essential when working with victims of crime.

The implementation of this new training curriculum has resulted in increased productivity and competency of claims verification staff.

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Victims of Crime Program

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OFFICE OF VICTIM SERVICES AND RESTITUTION

The California Department of Corrections' (CDC), Office of Victim Services and Restitution (OVSR), was established in 1988 as part of a growing commitment to victim awareness and assistance.

Department of Corrections (OVSR) staff

The OVSR examines and responds to the various needs of crime victims. It is also responsible for ensuring that correctional staff, inmates, parolees, and the general public recognizes and understands the impact of crime on victims.

The scope of OVSR continues to grow. Staff provides services focused on emphasizing the rights and needs of victims, and a commitment to improving the treatment of victims at all levels within the CDC. The OVSR provides the following services on a regular basis:

Special Conditions of Parole

Staff routinely assists crime victims requesting to be notified of an inmate's release from state prison. They also assist victims requesting special conditions of parole.

Such requests are handled through extensive contact by OVSR staff with the victim, family members, victim advocates, and institutions.

Restitution

Program staff also manages CDC's restitution activities. To date, CDC has collected over $30 million in restitution fines and direct orders to victims from inmate wages and trust account deposits.

In 1992, CDC implemented the Inmate Restitution Collection System. This system enables CDC to deduct 20 percent of inmate wages and other trust account deposits to pay court-ordered restitution fines and direct orders to victims.

When a parolee owes a restitution fine or a direct order to a victim and requests to reside in any other state, staff ensures that the parolee has satisfied all outstanding restitution obligations prior to his or her approval for out-of-state transfer.

Board of Prison Terms Hearings

A victim's next of kin, or any immediate family member of the victim may appear at any hearing conducted to review or consider the parole suitability or setting of a parole date for any inmate.

If requested, OVSR staff helps ensure that the victim is notified prior to the hearing and that an escort is provided.

HIV/AIDS Testing

Inmates may be required to submit to HIV/AIDS testing. OVSR staff contacts the institution's Chief Medical Officer and facilitates the release of the HIV/AIDS test results to the victim.

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Upcoming Event

Spring 2000 Training Seminar

Consistent with the Board's goal to develop and maintain partnerships with those who serve victims, the VOCP will hold a spring training seminar titled "Domestic Violence and Victim Compensation-Helping Victims and Their Families". The seminar will be held at the Renaissance Long Beach Hotel on March 27, 2000, in Long Beach, California.

Speakers will include members of the Los Angeles City and County Victim/Witness Assistance Centers, the Federal Victim/ Witness Assistance Office in Los Angeles, and other State agencies.

This free seminar is open to mental health care professionals, victim representatives, and members of the medical and mental health provider community who serve crime victims. The purpose of the seminar is to heighten awareness of the resources available to victims and strengthen the VOCP's working relationship with the victim services community. Some of the topics that will be addressed at the seminar include:

Helping a domestic violence victim file a claim for assistance:

- Who can help a victim file a VOCP application;
- What forms must be completed.

Mental health treatment for victims of domestic violence and their families:

- Standards of Care;
- Peer Review;
- Initial and Extended Treatment Plans;
- Child Life Specialists;
- Residential Security.

To register for this event, or for more information, please contact VOCP's outreach staff at 1-800-777-9229, or you may send an email to: lpaluda@boc.ca.gov.

Claims Processing Marathon

In an effort to provide optimum customer service, the VOCP continually evaluates claim and disposition processing methods. As a result, VOCP staff recently developed the concept of a claims processing marathon to reduce the inventory of claims to be processed.

In December 1999, various VOCP staff participated in a fifteen-hour claims processing marathon. Each region worked in a spirit of friendly competition to process the most claims. Goals were established for the number of VOCP claims that could be processed within the allotted timeframe, based on the varying staffing levels within each region.

Each region selected a name for the competition. These were: *"Claim Busters", "Reigning Deers", "South Coastal All-Stars", "Kickin Aceituno's", "LA Perfection",* and "*Can't Beat the Heat".*

During the marathon, various staff, including **Steve Hall, David Shaw, Maggie Watts, Fernando Garcia,** and **Michael Hawkins** made hourly announcements over the Board's public address system regarding each region's progress.

As a result of this concentrated effort by VOCP staff, a total of **1,275** claims were processed during the marathon. This is an outstanding accomplishment, considering that nearly one half of the fifty state victim compensation programs combined process **less** claims in an **entire year**.

Due to the outstanding success of this event, plans for a second claims processing marathon are currently underway.

NEW STREAMLINED PAYMENT PROCESS

In order to reduce claims processing time, the VOCP's Executive Staff developed a new method to process medical, funeral/ burial and income/support loss payments.

This new streamlined claims processing method is being implemented as a pilot project at the VOCP and in Joint Powers (JP) Victim/Witness Assistance Centers.

New applications received by the VOCP and all JP Centers will be screened by designated intake processing staff to identify those who meet specified streamline criteria.

Medical and Funeral/ Burial Expenses

If the claim meets the streamlined criteria, all medical or funeral/burial bills will be reviewed to determine if they qualify for payment within specified provider bill parameters.

Those bills that qualify will be entered into the VOX computer system and subsequently paid. A post review process will be utilized to assure verification of all claimed losses is completed.

Supplemental bills submitted for claims that meet the streamlined criteria and provider bill parameters will be paid according to this streamlined approach.

Income and Support Loss

Those claims that meet specific income/support loss streamlined criteria will be routed to specific staff who will allow for payment of up to 4 weeks of income or support loss. Supplemental income or support loss will be processed in the usual manner.

A post review process will be utilized to verify any paid income or support loss.

Claims that cannot be streamlined will be forwarded to the appropriate region or JP verifier to be verified and processed in the usual way.

It is projected that this new approach will significantly reduce bill processing time for approximately one-half of all bills submitted to the VOCP.

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"New Director"

four weeks to forty-two days.

As recognition for accomplishing enormous goals with record-setting efficiency, the Iowa Program recently received the **"Tadini Bacigalupi Award"** from the National Organization for Victim Assistance (NOVA). This award was established in 1981 to commend outstanding victim service programs.

Ms. Brodie has served as a technology consultant to other victim compensation programs, and has developed automated claims processing systems for five states.

"the burden of bearing the cost of crime should be with the offenders"

She previously served as a mentor under the Office of Victims of Crime, and has mentored 20 other state victim compensation programs in the areas of program evaluation, claims processing, and restitution.

In 1985, Ms. Brodie earned a Bachelor's Degree in Criminal Justice from Drake University in Des Moines, Iowa. In 1987, she received a Masters degree in Public Administration.

On a personal note, Ms. Brodie is married and has two children. Her family will soon be joining her in California.

She will integrate her experience, vision and compassion for victims, to ensure that the VOCP provides optimal services in the new millennium.

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Training/Presentations

OVSR staff provides training to CDC employees on the impact crime has on domestic violence, stalking, child molestation, rape victims, and families of murder victims. Staff provides training regarding victimization issues at academies, new employee orientation training, and annual training sessions. External training is provided at the national level and for correctional employees from other states.

Statewide training is provided for various agencies including the California District Attorney's Association, Chief Probation Officers' Association, Judges, State Board of Control, Victim/Witness Assistance agencies, McGeorge School of Law-Victim Resource Center, and other advocacy programs, legislators and their staff.

Staff serves as consultants to the National Victim Center, the National Organization for Victim Assistance, and the Federal Office for Victims of Crime. In addition, some staff are registered with the National Institute of Corrections as technical experts and trainers.

Educational Resources Available

An Impact of Crime on Victims Handbook was developed by OVSR in conjunction with the California Youth Authority (CYA). The purpose of the handbook is to emphasize the impact of crime on victims and to make offenders accountable for their crimes. The handbook is utilized as an educational tool by CDC staff in teaching inmates/parolees about the impact of their crimes on victims.

Nearly every institution and Community Correctional Reentry Center (CCRC) were provided with the Impact of Crime on Victims Handbooks, video tapes, and training by OVSR staff.

OVSR staff is currently updating the handbook and will be providing training at each institution and CCRC on how to implement the program within their facilities.

Fundraising

Each year during National Crime Victims Rights Week, the Director encourages each institution and parole region to conduct at least one fundraiser to benefit crime victims. Proceeds raised are donated to local non-profit victim service organizations. These activities have raised over $1.7 million for community-based victim service organizations.

National Crime Victims' Rights Week/ Child Abuse Prevention Month

OVSR coordinates the CDC's observance of National Crime Victims' Rights Week and Child Abuse Prevention Month each April.

Activities and Functions

Program staff is responsible for the printing and distribution of informational packets and posters to field staff. OVSR hosts an annual training forum and honors staff and community-based victim service providers. Staff also coordinates a statewide "Moment of Silence" in commemoration of crime victims, and coordinates CDC's participation at the "March on the Capitol".

Victim Service Representatives

Each institution and parole region is required to appoint at least one Victim Service Representative (VSR) to serve as a field liaison to the OVSR. Program staff stays in contact with the VSRs via a quarterly update and an annual training forum. The annual forum is conducted by OVSR staff using resources from throughout CDC and the State.

The training provides an opportunity for participants to network, share ideas, experiences, and program development.

The OVSR and similar programs provide an invaluable service to victims and their families.

THE NATIONAL CRIME VICTIM BAR ASSOCIATION

The National Crime Victim Bar Association is the nation's only bar association dedicated to advancing the field of civil justice for crime victims as a new law practice specialization. It is dedicated to facilitating civil actions brought by crime victims to hold responsible parties accountable for criminal actions.

The Association is a program of the **National Center for Victims of Crime** that facilitates civil legal remedies for crime victims by providing:

- referrals to qualified counsel in their geographic area;
- technical support for attorneys;
- practical advice to help attorneys effectively and compassionately interact with clients;
- training for victim service providers;
- public education about civil remedies;
- advocacy for legal change.

The Association provides information to attorneys on how to win civil cases through it's publications and continuing legal education seminars.

Another service for its attorney members, is it's Civil Justice Database, which contains more than 10,000 summaries of court decisions in civil cases involving crime victims.

The database represents the only collection of court decisions in civil cases involving crime victims and is an invaluable resource in this developing specialty of legal practice.

The Association also trains victim service providers on the basic principle of civil litigation for crime victims, so that they can inform victims of their right to consult with an attorney about pursuing a civil action.

The civil justice system can be a viable alternative that can empower victims of crime. In a civil case, the victim controls essential decisions that shape the case. It is the victim, not the state's prosecutor, who ultimately decides whether or not to sue, accept a settlement offer, or go to trial.

Having this kind of influence in the decision making process can provide victims and their families with a sense of justice.

In the civil justice system, the victim can hold the offender *personally* accountable for the crime, both morally and financially, because the defendant becomes liable to the victim, not the state.

Victim Advocate is a quarterly journal of the Association, featuring articles on new cases and trends, and highlighting the most recent appellate cases involving *victim v. perpetrator* litigation.

The Association's *Crime Liability Monthly* offers summaries of the latest published opinions in cases brought against third parties by victims of crime. Both of these publications are designed to disseminate information on representing crime victims in civil cases.

Through a successful civil lawsuit, victims of crime can begin healing from the physical, psychological, and financial injuries caused by crime.

"...the first duty of society is justice."

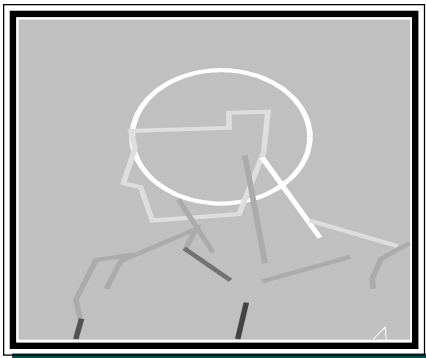
- Alexander Hamilton

Claims Denied During the 1998/99 Fiscal Year, By Denial Category

Denial Reason	Number of Claims	% of Claims
Lack of Evidence of a Crime	1,304	29.6
Deny: Applicant/Claimant Involvement in Crime	758	17.2
Lack of Cooperation with Law Enforcement	590	13.4
Not a Covered Crime	532	12.1
Claim Found to be a Duplicate	424	9.6
Late Claim	348	7.9
Ineligible Applicant/Claimant	299	6.8
Lack of Cooperation with the Board	43	1.0
Claim Withdrawn at Applicant/Claimant's Request	36	0.8
Emergency Award: Insufficient Information	33	0.7
Not a California Resident	18	0.4
Converted Claims: No Deny Reason Available	8	0.2
Miscellaneous	6	0.1
Deny Emergency Award: No Crime Report	4	0.1
Felon Status of Applicant	3	0.1
Emergency Award Deny or Rescind and Deny	2	-
Claimant is Deceased	2	-
All Reasons	4,410	100%

NOTE: The total denied represents only 9% of the 45,951 claims received.

Source: Board's Data Processing System



The QAMH READER

A Publication of the Quality Assurance Mental Health Unit of the Victims of Crime Program, State Board of Control

No. 3

Standards of Care Task Force Update

The California State Board of Control (BOC), Victims of Crime (VOC) program formed the Standards of Care Task Force in October 1998. The task force is comprised of persons with recognized expertise in the treatment of child trauma victims and includes representatives from each of the mental health disciplines, as well as 2 pediatricians who have experience in the treatment of abused children. The mission of the task force is to develop guidelines for the treatment of child trauma victims that will provide informed decision-making to the VOC program, as well as establish standards of care for mental health providers. The ultimate goals are to ensure that child trauma victims will receive timely, sufficient, and effective care in their recovery.

The task force has been meeting on a monthly basis **since October 1998 to formulate guidelines that are being developed into a comprehensive document. The document is in the final stages of completion and a technical editor is being retained for final review. The VOC program is currently involved in the process of selecting a publisher for the document. It is anticipated that the date of publication will be in June of 2000.**

The task force introduced the standards of care guidelines during the week of January 24-29, 2000 at the San Diego Child Maltreatment conference. During this conference, the task force was acknowledged by the BOC board members for their important contributions. One of the conference workshops consisted of a panel comprised of certain task force members, as well as VOC staff.

With the conclusion of the development stage of the task force recommendations, the VOC will begin an implementation phase to begin dissemination of these recommendations to the provider community. Special attention will be given to assure dissemination to providers of underserved populations. Certain task force members may be retained to serve as outreach advisors for this process. Additionally, because the VOC recognizes that the standards of care must be responsive to advances in research and clincal practice, some members of the task force will continue as an update committee. The update committee will periodically review the task force recommendations in the light of new research findings.

Post Traumatic Stress Disorder

This 3-part article on Post Traumatic Stress Disorder (PTSD) is the second in a series of articles to appear in the QAMH READER focused on diagnoses frequently seen in VOCP mental health claims.

This is the second of a 3-part article on Post-Traumatic Stress Disorder (PTSD). Part I described the recent history of attempts to understand the nature of the emotional trauma caused by stress, leading up to the formulation of the PTSD diagnosis in 1980. Part II will describe in more detail the causes and prevalence of the disorder in adults and changes in the criteria for diagnosis that were introduced in 1994. Part III will describe the same for children as there are differences between the typical child and adult responses.

The U.S. Surgeon General's Mental Health report describes causal factors of the disorder as follows:

> *PTSD symptoms generally manifest as anxiety and behavioral disturbances within the first 3 months after an extreme traumatic event. In some cases, however, symptoms are delayed for significant periods of months or even years. Such events include rape or other severe physical assault, near-death experiences in accidents, witnessing a murder, and combat.*

The DSM-IV further deliniates causal factors as:

> *those in which the traumatic event consists of direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's personal integrity; or witnessing an event which threatens the physical integrity of another person; or learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.*

In 1994, the DSM-IV established new criteria for the diagnosis of PTSD. The new criteria refined the diagnostic process by providing *specific* criteria which are required for a PTSD diagnosis. The criteria fall under 4 primary categories:

A. The person has been exposed to a traumatic event in which both of the following are present:
(1) the experience of a trauma (as previously defined); (2) the person's response involved intense fear, helplessness, horror.

B. Persistent reexperience of the trauma by one (or more) of the following:
(1) recurrent intrusive recollection of the trauma; (2) recurrent distressing dreams of the trauma; (3) acting or feeling as if the traumatic event was recurring; (4) Intense distress at exposure to trauma related cues; (5) physiological reactivity at exposure to trauma related cues.

C. Persistent avoidance and numbing responses to trauma associated stimuli, as indicated by three (or more) of the following:
(1) efforts to avoid trauma related thoughts and feelings; (2) efforts to avoid activities, places or people which arouse recollections of the trauma; (3) impaired recall of the trauma; (4) diminished interest in significant activities; (5) detachment or estrangement; (6) restricted range of affect; (7) sense of foreshortened future.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) sleep difficulties; (2) irritability or outburst of anger; (3) difficulty concentrating; (4) hypervigilance; (5) exaggerated startle reflex.

Prevalence rates for the disorder vary widely depending on the methods of ascertainment and population sampled but average at about 10% according to the American Psychological Association. Individuals at high risk for the disorder include war veterans, victims of violent crimes or severe natural disasters, and those who have recently emigrated from areas of considerable social unrest and civil conflict. Persons who have experienced maltreatment in childhood are at much higher risk for developing PTSD following an adult trauma. The disorder is seen twice as often in women than in men.

Research Features

The following is a summary of an article featured in Clinical Psychiatry News

Some Young Children Show Signs of a Violent Future

Although physicians and mental health providers cannot reliably identify children who go on to commit random acts of violence, such as in the recent school shootings in Colorado and Georgia, there appears to be a subset of children whose history of consistent aggressive behavior since toodlerhood makes them identifiable for future violence.

At a workshop on antisocial behavior in early childhood sponsored by the National Research Council and the Institute of Medicine, several specialists in the field discussed recent predictive studies in this area.

These consistently aggressive children differed from the perpetrators in the recent school shootings in that the shooting suspects did not have a reputation for being especially aggressive. The children identified in this workshop were termed, or were certainly at risk to become, "life-course persistent antisocial individuals". Many of these children, who often go on to be diagnosed with conduct or oppositional-defiant disorder, exhibit truly vicious behavior that is above and beyond the normal aggression and non-compliance typically seen in toddlers.

Studies indicate that these traits are predictive of later antisocial behavior; but it was also noted that there is a high rate of false positives. Another study noted that those toddlers deemed "uncontrollable" at age 3 were twice as likely to be involved in a life of crime by age 21. Between 25% to 33% of these identified toddlers go on to develop serious conduct or delinquency problems.

To a large extent, however, many of the workshop attendees agreed that these children can be identified and helped during early childhood. Unfortunately, many physicians and mental health providers are hesitant to refer aggressive children for mental health evaluation because they do not want the child to be stigmatized. Behavioral interventions appear to help to a mild to moderate degree.

Workshop participants also noted that up to 40% of children with conduct disorder also may have juvenile mania and that the mania is often sucessfully treated with mood stabilizers.

Additional information on this study can be found at: http://psychiatry.medscape.com/IMNG/ClinPsychNews/1999/v27.n07/cpn2707.05.01.html

The following is a summary of an article featured in news.excite.com

Stress Findings in US Teens

In a recent Rueters Health article, it was reported that one third of U.S. teens say they feel stressed-out on a daily basis. Additionally, in the study of more than 8,000 high school students and people in their early 20's, almost two thirds stated that they felt stressed at least once a week.

Some of the findings in this area indicate that American teens face greater amounts of stress because families and societies place unclear goals on them. As an example, American teens are encouraged to excel in school, have active social lives, be physically fit, and eventually have promising careers. Japanese parents and children typically focus solely academic achievement.

Researchers recommended that parents be clear about what they emphasize and help young people differentiate what's important.

The study was conducted by researchers at the University of Michigan, Ann Arbor.

Additional information on this study can be found at: http://news.excite.com/news/r/991027/13/health-tee1

NEW MENTAL HEALTH EVALUATIVE TOOLS FOR THE VOC PROGRAM: THE GARF AND SOFAS SCALES

The VOC program has recently began requiring the use of two additional mental health scales on the new Initial Treatment Plan (ITP) and the Extended Treatment Plan (ETP): the Global Assessment of Relational Functioning (GARF) Scale and the Social and Occupational Funtioning Assessment Scale (SOFAS). The VOC foresees receiving improved information about the progress of mental health treatment from the use of these scales.

Although the GARF and SOFAS have been widely available through their inclusion in DSM-IV (Appendix B), many, both in and out of the mental health profession remain unfamiliar with their function and usage.

According to the DSM-IV:

> The GARF Scale can be used to indicate an overall judgement of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship. It is analogous to Axis V (Global Assessment of Functioning Scale) provided for individuals in DSM-IV. The GARF Scale permits the clinician to rate the degree to which a family or other ongoing relational unit meets the affective or instrumental needs of its members in the following ways:
>
> Problem solving - skills in negotiating goals, rules, and routines; adaptability to stress; communication skills; ability to resolve conflict.
>
> Organization - maintenance of interpersonal roles and subsystem boundaries; hierarchical functioning; coalitions and distribution of power, control, and responsibility.
>
> Emotional climate - tone and range of feelings; quality of caring, empathy, involvement, and attachment/commitment; sharing of values; mutual affective responsiveness, respect, and regard; quality of sexual functioning.

The GARF Scale is scored in full point increments with five categories used to classify a given score. 81-100 is considered to be scoring in the satisfactory range. The descending ranges reflect decreased levels of relational functioning.

In regard to the SOFAS, the DSM-IV states:

> The SOFAS is used to consider social and occupational functioning on a contiuum from excellent functioning to grossly impared functioning. The SOFAS is a new scale that differs from the GAF Scale in that it focuses exclusively on the individual's level of social and occupational functioning and is not directly influenced by the overall severity of the individual's psychological symptoms. Also in contrast to the GAF Scale, any impairment in social and occupational functioning that is due to general medical conditions is considered in making the SOFAS rating. By contrast, the effects of lack of opportunity and other environmental limitations are not to be considered.

The SOFAS is scored on a continuum range of 100 (Excellent) to 0 (Inadequate information). Scores of 70 and above are considered between adequate to excellent functioning. Again, descending the continuum indicates decreased levels of social and occupational functioning.